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Direct Provider Subsidies for Safety Net or Charity Care Services

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Executive Summary

One way to assure that low-income, uninsured people have adequate access to needed health care is to directly fund health care providers for serving them. This "direct subsidy" strategy is an alternative to efforts to provide health insurance for this population. This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team concerning direct provider subsidy policy options.

Historically, the health care system has served uninsured people through charity care, which refers to health care provided to people who do not have the resources to purchase the care they receive or to pay the deductibles or co-insurance premiums required by a third party payer. Also referred to as uncompensated care, charity care services are overwhelmingly provided to people whose incomes are at or below 200 percent of the federal poverty level (FPL). Most hospitals, doctors, and other health care professionals provide charity care, although the burden falls disproportionately on a relatively small number of providers, called *safety net providers*.

Charity care is not free. The costs of providing charity care must be covered by other revenue: higher prices charged to other payers, charity contributions, or grants. Thus, a health care provider needs an adequate financial margin in order to be able and willing to provide charity care. In an environment in which public and private payers are focused on saving money and cutting payments, the ability of providers to meet the medical needs of uninsured families—or even to stay financially viable—is threatened and uncertain.

Direct subsidies to providers who serve the uninsured are one way to expand access. Supporters of this approach argue that such subsidies would make it more likely that providers will continue to serve the uninsured and are more efficient than using scarce resources to obtain health insurance. Proponents of the first neighborhood health centers in the 1960s argued that, "only a health center, as opposed to health insurance, could simultaneously treat a variety of causes of deficient medical care common to poverty areas" (Hegner, 2001).

The direct subsidy option includes three broad categories into which the strategies, or sub-options, can be classified:

- Money given to providers
- Tax credits for providers
- More designated safety net providers

Very little research exists to assess the effectiveness of directly subsidizing providers to expand charity care. However, the economic realities for health care providers—that the margin from which to cover charity care equals revenues minus expenses—suggest that subsidies could be one significant strategy to improve or maintain access. In 1983-1984, Washington State's policy makers considered one design option, a hospital uncompensated care pool, but political

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opposition prevented its implementation. Other design options examined in this policy paper involve expanding existing programs, including the Health Care Authority's Community Health Services grant program, tax credits for hospitals or health care professionals, increased premiums to state-contracted health plans, designations of all rural areas as Health Professional Shortage Areas (HPSAs), and designating more medical practices as Rural Health Centers (RHCs). Most direct subsidy strategies would entail significant financial and administrative barriers, not the least of which are effects on state expenditures.

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Direct Provider Subsidies for Safety Net or Charity Care Services

Overview of Policy Option

People seek health care whether or not they have the financial resources to pay. In 2000, approximately 484,000 Washington residents were uninsured, of which about two-thirds (308,000) could be considered too poor to pay some or all costs of care—those with incomes less than 200 percent of the federal poverty level (FPL). In general, this is the primary population whose access to care is dependent on the ability and willingness of health care providers to provide charity care or access to community and migrant health centers or similar designated safety net providers. Companion Research Deliverables 3.1 *Targeting the Uninsured in Washington State* and 3.3 *Income Adequacy and the Affordability of Health Insurance in Washington State* provide additional information about the affordability of health insurance in Washington.

In some, mostly urban areas of the state, which have many hospitals and physicians and designated safety net providers, it may be no problem if some health care providers decide not to treat uninsured patients. But in many small, rural communities, the small number of providers or absence of safety net providers places great pressure on existing providers to provide charity care even in the face of eroding margins—they *are*, in effect, the safety net. If even a few of these hospitals or medical clinics refuse to care for uninsured patients, access in those communities will be severely curtailed.

The universe of providers that serves the uninsured can be grouped into two categories: safety net providers—providers that serve a disproportionate share of charity care or are otherwise "designated" as safety net providers, such as community and migrant health centers or public hospitals—and all other providers. Safety net providers include certain urban hospitals (e.g., Harborview Medical Center), all sole community hospitals, and Community and Migrant Health Centers and Rural Health Centers, which have special federal status. The charity care load for safety net providers is significant. For example in 1999, 16 hospitals in Washington spent more than 3 percent of their adjusted revenue (excluding Medicare and Medicaid payments) for charity care (Department of Health, 2000). The Washington Association of Community and Migrant Health Centers (2002) reports that since 1992 the number of uninsured patients visiting the state's community health centers has grown by more than 34 percent.

Yet, some evidence suggests that safety net providers may not provide the bulk of the non-hospital charity care delivered in the state. A recent study of primary care practices in Washington State found that two-thirds of Medicaid visits in Washington were provided by primary care physicians whose practice revenues included less than 20% Medicaid (HPAP, 2001). To the extent that the distribution of Medicaid visits and charity care visits is similar, this finding implies that most outpatient charity care is probably provided by the balance of health care practices that may not individually see as many charity patients as safety net providers.

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For this diverse group of care providers to continue to meet the demand for charity care, they must have healthy operating margins. That is, their ability and willingness to provide charity care—which is care paid for with revenues generated from other sources—is dependent on having greater revenues than expenses:

REVENUE - EXPENSES = MARGIN

Without such margins, it will become increasingly difficult for providers to maintain, much less expand, existing commitments to low-income, uninsured patients. Indeed, Reed et al. (2001) found that physicians were reducing their provision of charity care, in part due to the financial strain of decreases in payments by employers and health plans, as well as losses in risk-contracts.

Direct subsidies to providers can be conceptualized in two specific ways with this equation in mind. The subsidy can either increase the medical practice's revenues or decrease its expenses to improve the total operating margin. This paper discusses strategies to increase revenues. Strategies to reduce expenses are addressed in Research Deliverables 4.2 *Administrative Simplification* and 4.4 *Community Access Initiatives*.

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Problem Definition and Target Population

Why this policy option?

Two basic methods exist to provide financial access to care for low-income, uninsured people: subsidize the costs of health insurance, with insurers then paying providers for care, or give providers additional revenues that will allow and entice them to provide charity care. In essence, subsidies add to the operating margin necessary for providers to continue meeting the medical needs of the uninsured. The first direct subsidies for community health centers (CHCs) were provided in the late 1960s when some CHCs began accepting direct payment for welfare clients (Green, 1970). Today, the federal government and various states, including Washington, have devised various subsidy mechanisms on which certain providers rely. For example, in 1999 Harborview Medical Center treated more than 23 percent of all hospital charity patients in the state, and Harborview was the single largest recipient of available public subsidies, which amounted to 12.8 percent of the hospital's total adjusted revenue (Department of Health, 2000).

Over the past several years, providers have been affected by many policy and market changes (HPAP, 2001). In particular, the "devolution" of responsibility for social programs from the federal government to the state and local levels has affected providers that serve the uninsured, including two key developments: the federal Balanced Budget Act (BBA) of 1997 and advent of Medicaid managed care (Institute of Medicine, 2001; Meyer, 2001; Norton, 1998). Through the BBA, Congress gave states more responsibility for administering Medicaid programs and decreased the total amount of federal dollars appropriated for graduate medical education and the usual disproportionate share hospital (DSH) payments, a federal direct subsidy program that provides funding to help hospitals care for the poor. Concurrently, most states moved most of their Medicaid beneficiaries into managed care plans (Washington's Healthy Options became a statewide program in 1993), which gave beneficiaries a choice of health plans and, in many

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cases, a greater choice of especially primary care providers than they had under the traditional fee-for-service system.

One net effect of these changes was that many Medicaid recipients left public providers for private providers. Many safety net providers, especially hospitals, lost Medicaid revenues, which in some cases was a large portion of patient revenues. On top of that effect, DSH payments are often based on the number of Medicaid patients served, so some hospitals lost an even greater amount of the money they used for charity care.

The demand for safety net providers is expected to increase due to the current economic recession and a rising unemployment rate. In October 2001, the U.S. Labor Department reported that Washington State had the highest unemployment rate in the country at 6.6 percent; by January 2002 it had climbed to 7.5 percent.* High unemployment rates tend to be related to higher rates of uninsurance—the Washington uninsured rate is highest for people with no employed family member (18.5 percent) and lowest among those with two earners in the family (3.8 percent). In families that had one employed member, the rate of uninsurance is 11.5 percent.†

Who is affected by this policy option?

The target population for this policy option is people who are uninsured and whose incomes are less than 200 percent of the federal poverty level, at which income level an individual is generally considered unable to purchase needed care.‡ The uninsured represent 8.3 percent of all Washington residents, but 9.2 percent of residents under age 65 (nearly all older adults are covered by Medicare) or about 484,000. Of this total, about 308,000, 64 percent, have incomes below 200 percent FPL. Another 15 percent of the uninsured are in families or households earning less than 300 percent FPL.*

Policy Design Options and Considerations

What the subsidy can be used for

This paper examines three broad categories for subsidizing providers: money given to providers, tax credits for providers, and more designated safety net providers. The proposed subsidies are designed to ease the financial burden of providers so that they will have the financial capacity to care for the uninsured. These categories and the corresponding eight sub-options have been considered or actually implemented in Washington and other states, or represent innovative approaches that we think hold some promise for subsidizing safety net providers.

* *Seattle Times*, November 21, 2002 and February 19, 2002.

† Washington State Planning Grant on Access to Insurance. Research Deliverable 3.1. *Targeting the Uninsured in Washington State*

‡ Ability to afford health care may range from 100% FPL to more than 250% FPL, depending on county of residence and family type, according to Research Deliverable 3.3, *Income Adequacy and the Affordability of Health Insurance in Washington State*.

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Design Option 1. Money given to providers

We have identified four ways the state could funnel money to providers for the purpose of serving the uninsured. The sub-options in this category range from the State Health Care Authority's Community Health Services existing grant program for community health centers to new innovative approaches that include creating a discount card for the uninsured and funding health plans that demonstrate an increase in the number of the uninsured served by the plans.

The idea of providing direct subsidies to providers as a way to address the uninsured "problem" was given impetus by President Bush's Health Centers Initiative. The initiative's goals are to add or expand 1,200 community health center sites over five years and double the number of patients treated, half of whom are expected to be uninsured. As of January 2002, the federal government has awarded 60 grants totaling $14.6 million, including a $133,333 grant to Community Health Association of Spokane for mental health and substance abuse services (U.S. DHHS, 2002).

A. Expand the Health Care Authority's Community Health Services grant program

Description: The state could expand the Health Care Authority Community Health Services (CHS) grant program above its current level of $6 million per year and distribute the money according to the number of uninsured people served by grantees (alternatively, it could expand the number of grantees, for example providing funds to non-safety net providers). In 2000, the program partially supported a total of 341,000 medical clients and 114,000 dental clients in 29 community and migrant health centers, public hospital-affiliated clinics, and local public health jurisdiction clinics. Program grants help pay for services for people whose incomes are less than 200 percent FPL and have no other health coverage, which comprise 41 percent of clinics' clients. The program especially targets the following groups:

- migrant seasonal farmworkers
- other minority populations
- people with HIV/AIDS infections
- people with developmental disabilities
- substance abusers
- mental health consumers
- uninsured low-income
- underserved low-income
- homeless
- elderly
- refugees
- geographically isolated

Financial considerations: To expand the program, the state would have to find additional funds within the state budget or from new revenues. Grantee clinics would benefit from additional grant funds by being able to expand capacity and serve more uninsured patients.

Administrative considerations: The administrative structure for the grant program is already in place, and no additional data would likely need to be collected from grantees or analyzed by HCA. This would not be true if CHS grants were made to other "mainstream" providers who do not, now, generate such data.

B. Create a discount card

Description: The state could create a program through which low-income, uninsured individuals could purchase an "Evergreen card" that would allow them to obtain care from participating

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providers. Providers, such as physicians, hospitals, and pharmacies, would agree to provide care to "Evergreen members" for which the members would pay reduced prices. The cost of the discount card might be the same for everyone under some income level, for example 250 percent of FPL, or could be a sliding scale set according to income. The state could implement this program using Community Health Services grantees as the provider network or preferred providers in the PEBB Uniform Medical Plan (UMP). Alternatively, the state could partner with one or more local communities or local provider networks that want to try a discount card approach. Such a partnership would build on local initiative and organization and allow the state to pilot discount cards in various locales.

Financial considerations: Creating a discount card program would require some start-up funds to define covered services, determine the discount card price(s), negotiate terms with participating providers, and initial marketing. Participating providers would, at least theoretically, benefit by receiving some income (discounted fees) for care for which they previously received nothing; however, CHS grantees may not share this benefit, as the individuals who are targeted by this option may already be receiving services at these community clinics for free.

Administrative considerations: Using providers already under contract to the Health Care Authority (CHS grantees or UMP providers) could minimize administrative and start-up costs for a discount card program. In addition, using "smart card" technology (magnetically recorded eligibility data on plastic cards that can be read in provider and program offices) could further reduce the administrative burdens of eligibility determinations and, thus, keep down costs for both clients and providers.

C. Increase payment to providers through increased health plan premiums

Description: The state—through Healthy Options or Basic Health—could increase premiums to contracting health plans that, in turn, could increase payment to providers to expand their ability to provide charity care. This strategy would require that a health plan be able to identify those of its providers that serve increased or at least certain numbers of uninsured patients (or percentage of revenues for charity care). The health plan would also have to determine how much to pay such providers. This would require new mechanisms for identifying providers within each plan that serve more of the uninsured as well as for the state to monitor the health plan's accuracy in identifying providers that serve the uninsured. These arrangements would be included in their state contract.

Financial considerations: The state would have to provide some incremental increase in health plan premiums, which would require that it shift funds from elsewhere in the state budget or find new revenues. This option may also require additional state administrative costs to monitor these charity care payments from health plans to providers and the resulting levels of charity care provided.

Administrative considerations: This design option would significantly change the relationship between the state and participating health plans. MAA and HCA have generally not intervened in the relationship between health plans and providers. To ensure that premium increases actually result in increased payments to providers, this strategy would likely require the state to stipulate the use of the added payments in health plan contracts. Each health plan would also have to create a mechanism for monitoring the volume or monetary value of charity care provided by its network providers. One way to potentially mitigate some negative effects of this option would be

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to direct additional payments only to Community Health Plan of Washington, which is owned by and whose providers are community and migrant health centers. These providers already are an important safety net for uninsured people, and they already collect and report services provided to this population.

D. Uncompensated care pools

Description: The state could set up an uncompensated care pool, which would enhance revenues for hospitals or other providers that provide a disproportionate amount of care to the uninsured. Uncompensated care pools can be financed in two different ways, internally and externally. Under internal financing,* the amount of money hospitals spend on charity care would be "pooled"; hospitals that provided more than the average amount of charity care would be able to draw a proportionate amount from the pool. The effect of an internally funded pool would be to redistribute revenues from "low" charity care hospitals to "high" charity care hospitals.

Under external financing, the state would find or create some outside source of funds, for example a dedicated tax. The resulting funds would be distributed to providers according to how much charity care each provides (either in number of patients or percentage of revenues). An external fund could target both outpatient care providers and hospitals, thus having the added benefit of bolstering *primary care* for charity patients, not just their inpatient care. A similar option would be to modify how the state allocates DSH funds in a way that encourages "mainstream" hospital and outpatient providers to serve the uninsured; however, existing DSH recipients could lose funding.

Financial considerations: For internally financed pools, the major issue is that some hospitals would receive additional revenues, while others would lose revenues. The benefit of an internally funded pool is that it would require no additional state funds. For externally financed pools, the major issue is finding a revenue source. In either case, providers would have a greater incentive to and capacity for providing charity care services.

Administrative considerations: A hospital-only pool would incur the fewest additional administrative costs, since a data-reporting system that includes charity care already exists (Comprehensive Hospital Abstract Reporting System or CHARS). A pool that includes non-hospital providers would require some additional data-reporting requirements and infrastructure, depending on which providers are involved (for example, community/migrant health centers and CHS grantees already report data on charity care, but private medical practices do not). In either case, the state would have to determine a threshold of charity care above which additional funds would be provided. The availability of pool funds could lead to inflated reports of charity care provided, so the state would have to monitor the quality of data provided.

Design Option 2. Tax credits for providers

Tax credits are a method of allowing providers to keep more of their revenues, thus enhancing that side of the "revenue - expenses = margin" equation. Through this strategy, providers would earn credits against their state Business and Occupation (B&O) tax liability by serving the uninsured. The tax credits would increase the margins for providers, which would enhance their

* Internal financing is only practical for hospitals, because the state has a well-established reporting system (CHARS) that provides a standard method of defining and pooling charity care. No similar system is available for outpatient services.

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capacity to serve uninsured patients. Tax credits are used in many cases to encourage certain behaviors, such as increasing capital investment by businesses.

A. Create a tax credit for not-for-profit hospitals

Description: The state could extend a Business and Occupation tax credit to not-for-profit hospitals, which includes nearly every hospital in Washington. The credit could be tied to the number of uninsured patients the hospital serves or the percentage of revenues used for charity care. For example, a hospital could receive a B&O credit of $1.00 for every $1.00 of charity care above 3 percent of total hospital revenues.

Financial considerations: Under this option, hospitals would have an additional financial incentive to serve charity patients. However, a B&O tax credit will result in lost revenue for the state budget.

Administrative considerations: The CHARS reporting system would allow the state to measure hospital charity care for purposes of this strategy. The state would have to determine the value of the B&O credit and what, if any, threshold to use (e.g., charity care provided above 3 percent of hospital revenues). Offering a tax credit could lead to inflated reports of charity care provided, so the state would have to monitor the quality of data provided by hospitals.

B. Create a tax credit for physicians, physician assistants, and nurse practitioners

Description: Similar to a hospital B&O tax credit program, the state could offer a B&O tax credit for physicians, physician assistants, and nurse practitioners who provide care for the uninsured. For example, a practitioner would receive a $1.00 tax credit for every $1.00 of charity care provided above 5 percent of gross charges.

Financial considerations: Under this option, health care practitioners would have an additional financial incentive to serve charity patients. However, a B&O tax credit will result in lost revenue for the state budget.

Administrative considerations: No system exists that defines and reports charity care provided by health care practitioners (except community/migrant health centers and CHS grantees). To implement this option, the state would need to create such a system, with resulting increases in administrative costs and additional reporting requirements for practitioners. Offering a tax credit could lead to inflated reports of charity care provided, so the state would have to monitor the quality of data provided.

Design Option 3. More designated safety net providers

Federally designated rural health clinics (RHCs) receive higher Medicare and Medicaid payments than private medical practices, generally leading to improved financial status of these private medical practices. According to estimates by Mike Bell and Associates, RHC certification increases federal and state payments by an average of $50,000 per year per FTE practitioner (DOH Policy Briefing, 2001). RHCs must be in federally designated Health Professional Shortage Areas (HPSAs), which includes most rural areas in Washington. Appendix B presents a map of Washington's federally designated HPSA's. Although the DOH Office of Community and Rural Health has been very aggressive in obtaining HPSA designations in

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Washington, not all areas that qualify have been so designated. In addition, more and more medical practices have expressed interest in RHC designation. This strategy would seek to designate more private medical practices as RHCs, thus stabilizing practices in communities where alternative sources of charity care are few.

A. Expand Federal Health Professional Shortage Areas (HPSAs)

Description: Federal regulations allow the governor to designate all eligible areas of the state as a Health Professional Shortage Area. With this status, providers in rural areas that are not now HPSAs could apply for rural health center designation. The governor-designation would be made using state-specific standards, subject to federal (HRSA) review. Such a process would add few new areas—nearly 90 percent of rural areas of the state are already designated—but it could provide a more stable and systematic method of knowing which areas are eligible.[*] The governors of Kansas and Nebraska have designated their entire states as Health Professional Shortage Areas.

Financial considerations: A governor-designation would require few additional resources and could reduce administrative costs over time by simplifying the re-designation process. However, state Medicaid spending could increase if such a designation does result in more RHCs. RHC-designated medical practices would have increased capacity to serve low-income patients.

Administrative considerations: Health Professional Shortage Areas are used by more than 37 federal programs to target federal resources, including rural health center status, Medicare bonus payments, and telemedicine reimbursements. The possibility of a "blanket" HPSA designation could provide some higher level of predictability and somewhat lower administrative complexity than the current piecemeal approach. However, RHC surveys have not been a high priority for the federal government, so designation may not quickly expand the number of medical practices that benefit from enhanced payments. In addition, the state would need to consider the implications of new proposed federal rules currently under review.

B. Expedite the application process for rural health center designation

Description: The state could provide staff to assist medical practices in applying for RHC designation. Seventy-five medical clinics have been designated as RHCs in Washington, but at least 40 other medical practices have expressed interest in obtaining or have applied for RHC status.[†] Appendix C presents a map displaying RHC locations throughout Washington.

Financial considerations: DOH would need to allocate additional staff resources and, if successful in obtaining additional RHC designations, state Medicaid spending could increase. RHC-designated medical practices would have increased capacity to serve low-income patients.

Administrative considerations: Allocating additional DOH staff to assist in RHC applications could ease the administrative burden of seeking designation for private practices. However, even with additional state staff, the situation is unlikely to change very soon, because the federal government has instructed the state Department of Health (which surveys RHCs on behalf of the federal government) to give new RHCs lowest priority due to budget concerns (DOH Policy Briefing, 2001). At this time, delays in the survey process can last at least several months.

[*] Personal communication from Vince Schueler, Washington State Department of Health, November 9, 2001.
[†] Personal communication from Vince Schueler, DOH Health Care Access Analyst, April 23, 2002.

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Evidence

For the most part, the research and policy literature concerning direct subsidies for charity care and safety net providers has been limited to descriptive accounts. Few studies have examined the effectiveness of direct subsidy strategies on charity care services or the safety net, although a few evaluations focus on uncompensated care pools. As a result, most of the evidence compiled for this paper is anecdotal or based on the experience of people who work in this arena, including providers, policy experts, and people in the states that are developing innovative strategies to subsidize safety net services.

Money given to providers

We did not find any evaluative studies that examine whether direct subsidies given for the purpose of expanding charity care actually result in extending care to greater numbers of the uninsured. The momentum behind this type of policy option may be, in part, an intuitive sense that improving providers' financial margins will result in greater stability and, therefore, willingness to serve the uninsured—this "cost-shift" mechanism is widely acknowledged as how the American health care system has financed charity care in the past. In the Primary Care Provider Study (HPAP, 2001), providers who participated in focus groups reported that the revenue enhancements they received as a result of RHC designation helped stabilize their practices. The Community Health Services grant program funds an increasing number of patients each year, which also gives credence to the argument that additional revenues can increase capacity for and actual service to the uninsured.

Discount cards

Discount card programs have been implemented in Hawaii and Arizona; information was readily available only on the latter. The Arizona Latin American Medical Association (ALMA), a nonprofit 501 c(3) organization, implemented a discount card through a partnership with providers. The St. Luke's Health Initiative funded the initial costs for this pilot project with a $68,500 grant.

The ALMA program, which began with a pilot test site in Maricopa County (Phoenix area), provides uninsured individuals access to doctor visits, hospital visits, prescription drugs, and radiology services. The card costs $40 and offers a 25 percent discount on services for all family members, regardless of the number of family members, and a 70 percent discount on radiology services. More than 700 Phoenix-area families have enrolled in this network of 60 providers and three hospitals. Organizations that sell the card, such as doctors' and lawyers' offices, split the $40 fees with ALMA. ALMA uses its $20 to cover the administrative costs of operating the program. Marketing, expenses for which have been minimal, has been conducted primarily through public service announcements on the radio and television and in newspapers. These efforts have especially targeted the Hispanic population, which typically has higher rates of uninsurance in Arizona.

Increase payment to providers by increasing health plan payments

No other state has attempted to funnel money to support charity through state-contracted health plans, although it was one option considered in the State Primary Care Provider Study. That study noted that using existing contractual relationships between the state and health plans could,

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on one hand, make use of existing administrative and payment structures. On the other hand, it would entail a significant departure from the state's hands-off role in health plan-provider relationships (including payment type and level) and would require significantly new administrative burdens (for data reporting and payment) for both health plans and providers (HPAP, 2001). In addition, using health plan premiums may not be the most efficient way of getting additional funds to providers to expand charity care for the uninsured.

Uncompensated care pools

Since the 1980s, several states have created uncompensated care pools to subsidize charity care services. During that decade, uninsurance rates rose as a result of recession, rapid health care cost inflation, and structural changes in labor markets (Bovbjerg, 2000). These trends increased the demand for uncompensated care and made the idea of pooling the burden of uncompensated or charity care across providers very appealing. In 1983-1984, policy makers in Washington State considered an internally financed hospital uncompensated care pool, but it failed to generate sufficient political support to be implemented.

Massachusetts, New Jersey, New York, and California currently operate some form of uncompensated care pool. We provide information below about New York's and New Jersey's programs as illustrative of such strategies.

New York

In 1983, New York implemented a program of four uncompensated care pools: a bad debt and charity care pool; a discretionary pool; a pool for financially distressed hospitals; and a pool for community health centers to help in their transition to managed care. Hospitals receive payments from the first three pools according to a formula that accounts for total inpatient uncompensated care charges adjusted to costs and outpatient department deficits (DeLia, 2001). One study found that New York's uncompensated care pools increased total adjusted admissions among indigent patients by 40 percent (the appropriateness or outcomes of this increased utilization was not analyzed). The pools also improved the financial condition of hospitals that provided the bulk of uncompensated care, increasing their margins (DeLia, 2001).

New Jersey

New Jersey implemented its first uncompensated care pool in 1987. Beginning in 1996, the pool was funded from surpluses in the state unemployment insurance (UI) trust fund, but this mechanism was meant to be provisional after hospital rate setting was phased out. In 1997, a doubling of tobacco taxes became the main funding source for the next five years of the pool, through 2002.

Tax credits

Until 1993, not-for-profit and public hospitals in Washington State enjoyed a special tax status that excluded most income from the B&O tax. One of the features of the 1993 Health Services Act was an agreement by the hospitals to accept a B&O tax on their non-governmental revenue to help fund expansion of coverage through Basic Health. Hospitals would, theoretically, have benefited, because their charity care burdens would fall as more residents became insured. The repeal of the 1993 act and budgetary limits on BH growth have undermined at least part of that agreement. According to analysts at the Washington State Hospital Association (WSHA), no

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other state has used tax-credit strategies specifically to enhance the capacity of providers to serve the uninsured.

More safety net providers

Rural areas of Washington State tend to have the fewest number of designated safety net providers and the highest rates of the uninsured. The 15-county East Balance Region (defined by the Washington State Population Survey as the rural counties of eastern Washington), for example, has the highest uninsured rate, at 15.7 percent. Conversely, the greatest concentration of community/ migrant health centers is along the I-5 corridor in the western part of the state. This leaves gaps in many rural regions of the state where no designated safety net providers exist (see map in Appendix A).

Washington State Experience

As with most states, Washington has employed two parallel strategies to improve access for uninsured people: public insurance program expansions and direct support for safety net and other providers that serve this population. Health care providers in Washington have a reputation of providing charity care services, and the state's safety net system is viewed as being strong and relatively stable (Holahan, 2002). In addition, various public programs support the provision of charity care services, including the State Health Care Authority's Community Health Services grant program and a number of federal programs.

Two general kinds of community health centers exist in Washington: community and migrant health centers and rural health centers. The Washington Association of Community and Migrant Health Centers (WACMHC) counts 21 organizational members (community health centers, migrant health centers, rural health centers, homeless health centers, health district centers, and hospital-affiliated health centers) with 60 clinics around the state. In 2000, these community health centers cared for 318,400 patients, of which 110,500, or 29 percent, did not have insurance and paid fees according to a sliding fee scale. In all, uninsured individuals made 300,600 visits to WAMHC-affiliated centers (Washington Association of Community and Migrant Health Centers, 2001).

As of February 2002, 70 medical practices were designated as rural health clinics (RHCs) in Washington. No centralized reporting mechanism exists for RHCs, which means that data on the number of uninsured served by these providers do not exist.

The maps in Appendices A and C reveals geographic gaps where community/migrant health centers and rural health clinics operate. These clinics tend to be located near population clusters leaving many rural areas in this state without designated non-hospital safety net providers. The burden of charity care in these communities falls on other health care providers. As presented in the State Primary Care Provider Study (HPAP, 2001), if the distribution of charity care is similar to Medicaid, most unpaid care is provided by the array of non-safety net medical providers.

Among hospitals, the demand for charity-care services increased by 10.4 percent from 1997 to 1999, growing from $102 million to $112.6 million (Department of Health, 1999). This burden is not shared equally among hospitals; 19 urban hospitals each provided $2 million or more in charity care, accounting for approximately 76 percent of all charity care provided by hospitals

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statewide in FY 1999 (Department of Health, 1999). In addition, hospital charity care provision varies considerably among different areas of the state (See table 1). Hospitals in King County provide the largest proportion of charity care, but this picture changes dramatically when Harborview Medical Center's $26.6 million in charity care is excluded. Excluding Harborview, charity care in King County drops from 2.44 percent to 1.51 percent of adjusted revenue (excluding Medicare and Medicaid revenue) (Department of Health, 2000).

Table 1. Hospital Charity Care as a Percentage of Adjusted Revenue, By Region, 1999

Hospital Region	1999
King County	2.44%
Puget Sound	1.79%
Southwest Washington	2.27%
Central Washington	2.37%
Eastern Washington	1.76%
Statewide	**2.19%**

Source: Washington Department of Health Hospital Financial Data Year-end Reports FY 1999

In 1999, 44 hospitals were classified as rural in Washington, most of which are small; two-thirds have fewer than 45 set-up beds. Rural hospitals reported total charity care of $8.8 million in 1999, generally less than their urban counterparts. For rural hospitals, charity care averaged 1.5 percent of adjusted revenue; charity care for urban hospitals averaged 2.3 percent of adjusted revenue. In 1999, charity care was less than one percent of total revenue for 37 of the 44 rural hospitals (Department of Health, 1999).

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Implications

Policy options involving direct subsidies must recognize the two major types of providers who serve uninsured people, designated safety net providers and the broader array of providers that, in total, probably provide the bulk of charity care in Washington State. The eight strategies addressed here aim to provide financial support, in different ways, to providers in order to enhance their ability and willingness to serve charity care patients. That is, they attempt to increase provider revenues and, thus, their net margins; it is these margins from which charity care may be financed. Although little empirical evidence is available to show that such strategies work, the financial realities facing providers, experience, and President Bush's Health Center Initiative all lend credence to the use of direct provider subsidies.

However, subsidizing providers directly for the purpose of expanding charity care is problematic for the following reasons:

Administrative issues—In order to direct subsidies in the right amount to the right providers, policymakers would need to be able to measure the volume, frequency, and cost of services provided to low-income, uninsured people by providers. Except for hospitals and some safety net clinics, such data systems and reporting requirements do not exist; creating them would entail considerable costs and new administrative burdens.

Financial issues—Although direct subsidies would likely help providers maintain or expand their capacity to provide charity care services, a number of these strategies would require increased state spending both for the services themselves and to manage the subsidy programs.

Outcomes—Little solid evidence exists that direct subsidies to providers would expand access for low income, uninsured individuals, even though subsidy programs are widely viewed as being critical resources for this population.

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Appendices

A. Community and Migrant Health Centers and Dental Clinics in Washington

B. Federally Designated Health Professional Shortage Areas in Washington

C. Rural Health Centers in Washington

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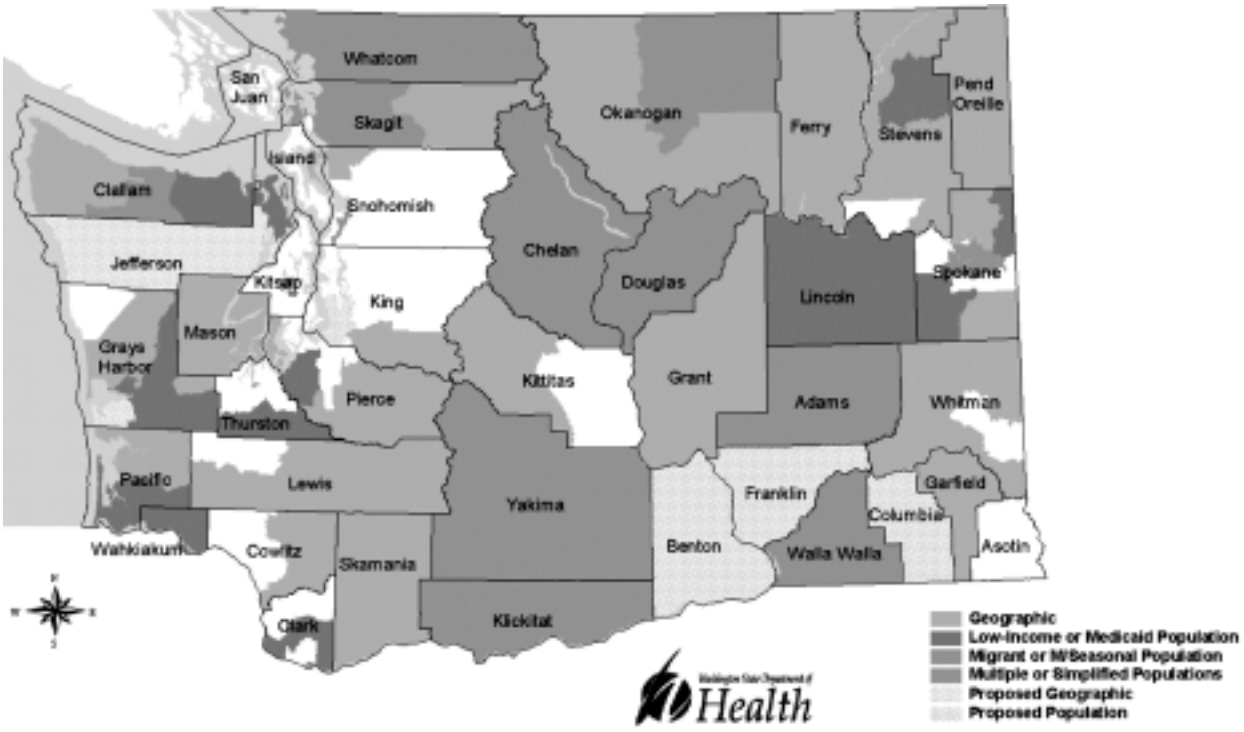
Appendix A

Community and Migrant Health Centers and Dental Clinics in Washington

Source: Department of Health, Office of Community and Rural Health, 2002

Appendix B

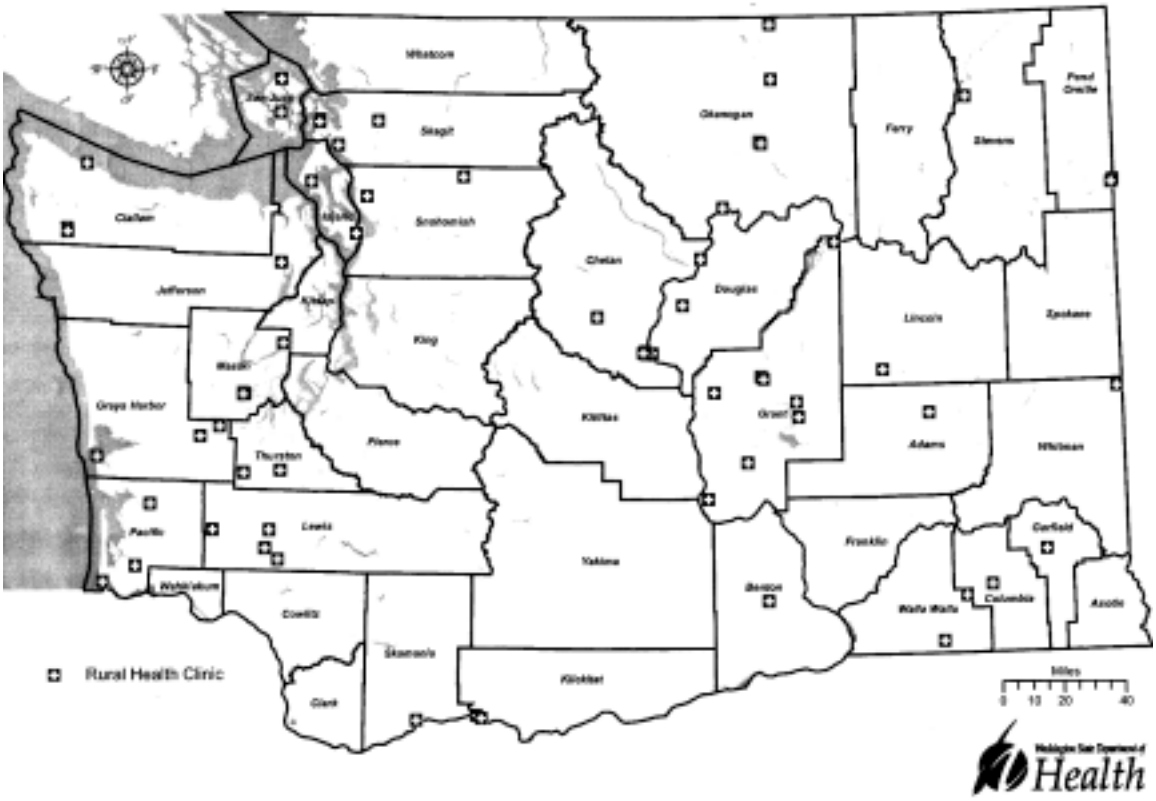
Federally Designated Health Professional Shortage Areas in Washington



Source: Department of Health, Office of Community and Rural Health, 2002

Appendix C

Rural Health Centers in Washington



Source: Department of Health, Office of Community and Rural Health, 2002